

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-031905

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

042

1000

Registrar's No. 1008

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

FILED OCT 9 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>DeKalb</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>		Length of stay in 1b <u>6 Mos.</u>		c. CITY OR TOWN <u>Pattersonburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Mo. Methodist Hosp.</u>				d. STREET ADDRESS (If outside, give location) <u>RR # 1</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> Middle <u>Botts</u> Last <u>Botts</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10-4-1899</u>	
9. AGE (last birthday) <u>61</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>DeKalb Co. Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13a. FATHER'S NAME <u>Robt. Coucher</u>				13b. MOTHER'S MAIDEN NAME <u>ANN MOORE</u>		14. NAME OF HUSBAND OR WIFE <u>Deceased</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Leona Tunks, Maysville, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Hypertension Arterial</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
20f. CITY, TOWN, OR LOCATION				COUNTY STATE			
21. I attended the deceased from <u>10-1-61</u> to <u>10-2-61</u> and last saw her/him alive on <u>10-1-61</u> Death occurred at <u>4:25</u> <u>9</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>H.C. Senne MD</u>				22b. ADDRESS <u>223 n 7th St Joseph Mo</u>		22c. DATE SIGNED <u>10-2-61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>10-2-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town, or county) (State) <u>OSBORN, Mo.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Poland Funeral Home, Cameron, Mo</u>				25. DATE RECD. BY LOCAL REG. <u>Oct. 3, 1961</u>		26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Woodell</u>	

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

H.C. Senne, M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Laurence J. Thompson

Licensed Embalmer No. 4735

P. O. Address Cameron, Md.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.